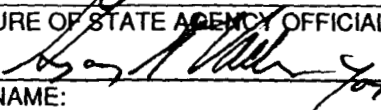
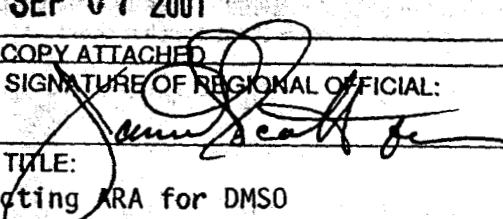


<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b> <b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		1. TRANSMITTAL NUMBER: <u>0 1 — 0 4</u>	2. STATE: <b>Missouri</b>
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE  <b>January 1, 2001</b>	
		5. TYPE OF PLAN MATERIAL (Check One):  <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT	
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: <b>Medicare, Medicaid &amp; SCHIP Benefits Improvement &amp; Protection Act of 2000 (Section 702 BIPA 2000)</b>		7. FEDERAL BUDGET IMPACT: a. FFY <u>01</u> \$ <u>0</u> b. FFY <u>02</u> \$ <u>0</u>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>Attachment 4.19B Pages 7, 8, 19, 26, 39, 45, and 46</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  <b>Attachment 4.19B Pages 7, 8, 19, 26, 39, 45, and 46</b>	
10. SUBJECT OF AMENDMENT: Add required change in payment methodology in accordance with Section 02 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. Also add supplemental payments to FQHCs, Independent and Provider-Based Rural Health Clinics for Medicaid Managed Care recipients.			
11. GOVERNOR'S REVIEW (Check One): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <i>JP</i> <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO:	
13. TYPED NAME: <b>Dana Katherine Martin</b>			
14. TITLE: <b>Director</b>			
15. DATE SUBMITTED: <b>March 29, 2001</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: <b>03/30/01</b>		18. DATE APPROVED: <b>SEP 07 2001</b>	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>01/01/01</b>		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: <b>Nanette Foster Reilly</b>		22. TITLE: <b>Acting IRA for DMSO</b>	
23. REMARKS:  <div style="display: flex; justify-content: space-between;"> <div>           cc:            Martin            Vadner            Waite            CO         </div> <div>           SPA CONTROL            Date Submitted 03/29/01            Date Received 03/30/01         </div> </div>			

Substitute per letter dated 7/19/01

Attachment 4.19-B

Page 7

Rev. 7/90

State Missouri

Federally Qualified Health Center (FQHC) Services

- (1) Pursuant to Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000), this alternative payment methodology for FQHC services has been agreed to by the State and the FQHCs and results in a payment to the center in an amount which is at least equal to the minimum rate which would be established under the Prospective Payment System methodology.
- (2) General Principles.
  - (A) The Missouri Medicaid Assistance Program shall reimburse FQHC providers based on the reasonable cost of FQHC covered services related to the care of Medicaid recipients (within program limitation) less any copayment or deductible amounts which may be due from Medicaid recipients effective for services on and after July 1, 1990.
  - (B) Reasonable costs shall be determined by the Division of Medical Services based on desk review of the applicable cost reports and shall be subject to adjustment based on field audit. Reasonable costs shall not exceed the Medicare cost principles set forth in 42 CFR Part 413.
  - (C) Reasonable costs shall be apportioned to the Medicaid program based on a ratio of covered charges for beneficiaries to total charges. Charges mean the regular rate for various services which are established uniformly for both Medicaid recipients and other patients.
  - (D) FQHC'S must use the Medicare cost report forms and abide by the Medicare cost principles, limitations and/or screens as through the FQHC was certified for Medicare participation as a Federally Funded Health Clinic (FFHC).
  - (E) FQHC'S which are not certified for participation as an FFHC must provide an independent audit which is also consistent with the principles and procedures applied by Medicare in satisfying its audit responsibilities.
- (3) Non Allowable Costs. Any costs which exceed those determined in accordance with the Medicare cost reimbursement principles set forth in 42 CFR Part 413 are not allowable in the determination of a provider's total reimbursement. In addition, the following items are specifically excluded in the determination of a provider's total reimbursement.

State MissouriFederally Qualified Health Center (FQHC) Services (cont.)

- (A) Grants (other than Public Health Services Grants under section 329, 330 or 340 of the Public Health Services Act), gifts and income from endowments will be deducted from total operating cost;
  - (B) The value of services provided by non-paid workers, including members of an organization having an agreement to provide those services;
  - (C) Bad debts, charity and courtesy allowances; and
  - (D) Return on equity capital.
- (4) Interim Payments.
- (A) FQHCs shall be reimbursed on an interim basis, up to ninety-seven percent (97%) of their charges for covered services billed to the Medicaid program. Interim billings will be processed in accordance with the claims processing procedures for the applicable programs.
  - (B) An FQHC in a Medicaid managed care (MC+) region shall be eligible for supplemental reimbursement of up to ninety-seven percent (97%) of MC+ charges. This reimbursement shall make up the difference between ninety-seven percent (97%) of the FQHC's MC+ charges for a reporting period, and payments made by the MC+ health plans to the FQHC for covered services rendered to MC+ patients during that period. The supplemental reimbursement shall occur pursuant to the schedule agreed to by the division and the FQHC, but shall occur no less frequently than every four (4) months. Supplemental reimbursement shall be requested on forms provided by the division. Supplemental reimbursement for MC+ charges shall be considered interim reimbursement of the FQHC's Medicaid costs.
- (5) Final Settlement.
- (A) An annual desk review will be complete following submission of the Medicare cost report (HCFA-242) and supplemental Missouri Medicaid schedules. The Division of Medical Services will make an additional payment to the FQHC when the allowable reported Medicaid costs exceed interim payments made for the cost reporting period. The FQHC must reimburse the division when its allowable reported Medicaid costs for the reporting period are less than interim payments.
  - (B) The annual desk review will be subject to adjustment based on the results of a field audit which may be conducted by the division or its contracted agents.

## INDEPENDENT RURAL HEALTH CLINIC PROGRAM

- (1) Pursuant to Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000), this alternative payment methodology for Independent Rural Health Clinic (IRHC) services has been agreed to by the State and the IRHCs and results in a payment to the clinic in an amount which is at least equal to the minimum rate which would be established under the Prospective Payment System methodology.
- (2) Qualifications. For a clinic to qualify for participation in the Medicaid Independent Rural Health Clinic program, the clinic must meet the following criteria:
  - (1) Must be an independent facility, which means that the clinic may not be part of a hospital. However, a clinic may be located in the same building as a hospital, as long as there is no administrative, organizational, financial or other connection between the clinic and hospital.
- (3) General Principles.
  - (1) The Missouri Medical Assistance (Medicaid) program shall reimburse Independent Rural Health Clinic (IRHC) providers based on the reasonable cost of IRHC-covered services related to the care of Medicaid recipients (within program limitations) less any co-payment or other third party liability amounts which may be due from Medicaid recipients.
  - (2) Reasonable costs shall be determined by the Division of Medical Services based on desk review of the applicable cost reports and shall be subject to adjustment based on field audit. Reasonable costs shall not exceed the Medicare cost principles set forth in 42 CFR Part 413.
- (4) Definitions. The following definitions shall apply for the purpose of this regulation.
  - (1) Desk review. The Division of Medical Services' review of a provider's cost report without on-site audit.

- (O) Salaries, wages or fees paid to nonworking officers, employees or consultants;
- (P) Value of services (imputed or actual) rendered by nonpaid workers, or volunteers; and
- (Q) Costs of services performed in a satellite clinic, which does not have a valid Medicaid participation agreement with the Department of Social Services for the purpose of providing RHC services to Title XIX-eligible recipients.

## (15) Interim Payments.

- (A) Independent RHC's, unless otherwise limited by regulation, shall be reimbursed on an interim basis by Medicaid at the Medicare RHC rate. Interim payments shall be reduced by co-payments and other third party liabilities.
- (B) An independent RHC in a Medicaid managed care (MC+) region shall be eligible for supplemental reimbursement of its MC+ RHC visits, up to the amount of its Medicare/Medicaid RHC rate for each MC+ visit. This reimbursement shall make up the difference between the total payable to the independent RHC at its rate per visit for MC+ RHC visits in a reporting period, and payments made by the MC+ health plans to the RHC for covered services rendered to MC+ patients during that period. The supplemental reimbursement shall occur pursuant to the schedule agreed to by the division and the independent RHC, but shall occur no less frequently than every four (4) month. Supplemental reimbursement for MC+ visits shall be considered interim reimbursement of the RHC's Medicaid costs.

## (16) Reconciliation.

- (A) The state agency shall perform an annual desk review of the Medicaid cost reports for each RHC's fiscal year and shall make indicated adjustments of additional payment or recoupment, in order that the RHC's net reimbursement shall equal reasonable costs as described within this section.
- (1) The total reimbursement amount due the RHC for covered services furnished to Medicaid recipients is based on the Medicaid cost report and is calculated as follows:
  - (a) The average cost per visit is calculated by dividing the total allowable cost incurred for the reporting period by total visits for RHC services furnished during the period. The average cost per visit is subject to tests of reasonableness which may be established in accordance with this regulation or incorporated in the Allowable Cost per visit as determined on Worksheet 3.A., line 7.

PROVIDER-BASED RURAL HEALTH CLINIC PROGRAM

- (1) Pursuant to Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000), this alternative payment methodology for Provider-Based Rural Health Clinic (RHC) services has been agreed to by the State and the IRHCs and results in a payment to the clinic in an amount which is at least equal to the minimum rate which would be established under the Prospective Payment System methodology.
- (2) Qualifications. For a clinic to qualify for participation in the Medicaid Provider-Based RHC Program, the clinic must meet all of the following criteria:
  - (A) The clinic must be an integral part of a hospital, skilled nursing facility, or home health agency;
  - (B) The clinic must be eligible for certification as a Medicare Rural Health Clinic in accordance with 42 Code of Federal Regulations (CFR) 405 and 491; and
  - (C) The clinic must be operated with other departments of the hospital, skilled nursing facility or home health agency under common licensure, governance and professional supervision.
- (3) General Principles.
  - (A) The Missouri Medicaid program shall reimburse provider-based rural health providers based on the reasonable cost incurred by the RHC to provide covered services, within program limitations, related to the care of Medicaid recipients less any copayment or other third party liability amounts that may be due from the Medicaid eligible individual.
  - (B) Reasonable costs shall be determined by the Division of Medical Services based on a desk review of the applicable cost reports and shall be subject to adjustment based on field audit. Reasonable costs shall not exceed the Medicare cost principles set forth in 42 CFR Part 405 and 413.
- (4) Definitions. The following definitions shall apply for the purpose of this rule:
  - (A) Desk review. The Division of Medical Services' review of a provider's cost report without on-site audit;
  - (B) Division. Unless otherwise designated, division refers to the Division of Medical Services, a division of the Department of Social Services charged with the administration of Missouri's Medical Assistance (Medicaid) program;
  - (C) Facility fiscal year. The clinic's twelve (12) month fiscal reporting period that corresponds with the fiscal year of the hospital, skilled nursing facility, or home health agency that the clinic is based.

- (B) A provider-based RHC in a Medicaid managed care (MC+) region shall be eligible for supplemental reimbursement of its MC+ RHC visits, up to the amount of its Medicaid interim RHC rate for each MC+ visit. This reimbursement shall make up the difference between the total payable to the provider-based RHC at its Medicaid rate for MC+ RHC charges in a reporting period, and payments made by the MC+ health plans to the RHC for covered services rendered to MC+ patients during that period. The supplemental reimbursement shall occur pursuant to the schedule agreed to by the division and the provider-based RHC, but shall occur no less frequently than every four (4) months. Supplemental reimbursement for MC+ visits shall be considered interim reimbursement of the RHC's Medicaid costs.
- (8) Reconciliation.
- (A) The state agency shall perform an annual desk review of the Medicaid cost reports for each provider-based RHC's fiscal year and shall make indicated adjustments of additional payment or recoupment, in order that the provider-based RHC's net reimbursement shall equal reasonable costs as described in this section.
- (B) Notice of program reimbursement. The division shall send written notice to the provider-based RHC of the following:
1. Underpayments. If the total reimbursement due the RHC exceeds the interim payments made for the reporting period, the division makes a lump-sum payment to the RHC to bring total interim into agreement with total reimbursement due the RHC.
  2. Overpayments. If the total interim payments made to an RHC for the reporting period exceed the total reimbursement due the RHC for the period, the division arranges with the RHC for repayment through a lump-sum refund, or if that poses a hardship for the RHC, through offset against subsequent interim payments or a combination of offset and refund.
- (C) The annual desk review will be subject to adjustment based on the results of a field audit that may be conducted by the division or its contracted agents.

- (9) Sanctions.
- (A) The division may impose sanctions against a provider in accordance with 13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services or any other sanction authorized by state or federal law or regulation.
  - (B) Overpayments due the Medicaid program from a provider shall be recovered by the division in accordance with 13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services.
- (10) Appeals. In accordance with sections 208.156 and 621.055, RSMO (1994), providers may seek hearing before the Administrative Hearing Commission of final decisions of the director, Department of Social Services or the Division of Medical Services.
- (11) Payment Assurance.
- (A) The state will pay each RHC, which furnishes the services in accordance with the requirements of the state plan, the amount determined for services furnished by the RHC according to the standards and methods set forth in the regulations implementing the RHC Reimbursement Program.
  - (B) RHC services provided for those recipients having available Medicare benefits shall be reimbursed by Medicaid to the extent of the coinsurance and deductible as imposed under Title XVIII.
  - (C) Where third-party payment is involved, Medicaid will be the payor of last resort.
  - (D) Regardless of changes of ownership, management, control, leasehold interest by whatever form for any RHC previously certified for participation in the Medicaid program, the department will continue to make all the Medicaid payments directly to the entity with the RHC's current provider number and hold the entity with the current provider number responsible for the Medicaid liabilities.
- (12) Payment in Full. Participation in the Medicaid program shall be limited to providers who accept as payment in full, for covered services rendered to Medicaid recipients, the amount paid in accordance with these regulations and applicable co-payments.

#### DIABETIC EDUCATION AND SUPPLIES

The state agency will establish rates for reimbursement as defined and determined by the Division of Medical Services in accordance with 42 CFR 447 Subpart D. Reimbursement will be made at the lower of:

- (1) The provider's billed charge for the service or
- (2) The Medicaid maximum allowable fee for the service.

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State Plan TN# 01-04  
Supersedes TN# 98-10

Effective Date January 1, 2001  
Approval Date SEP 07 2001